**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| **In the Matter of the Petition for Termination of Probation of:** | ) | |
| **Joseph Ralph Sicignano, M.D.** | ) | **Case No. 800-2016-020497** |
| **Physician's and Surgeon's Certificate No. G21095** | ) | |
| **Respondent** | ) | |

## DECISION

**The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.**

**This Decision shall become effective at 5:00 p.m. on August 31, 2017 .**

**IT IS SO ORDERED August 1, 2017.**

**MEDICAL BOARD OF CALIFORNIA**

**By:** Michelle Anne Bholat MD
**Michelle Bholat, M.D., Chair**
**Panel B**

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

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| In the Matter of the Petition for Termination of Probation of:<br><br>JOSEPH SICIGNANO, M.D.,<br><br>Physician's and Surgeon's Certificate Number G21095,<br><br>Petitioner. | Case No. 800-2016-020497<br><br>OAH No. 2016110683 |

**PROPOSED DECISION**

Administrative Law Judge Carla L. Garrett heard this matter on March 30, 2017, at Los Angeles, California.

James Victor Kosnett, Attorney at Law, represented Joseph Sicignano, M.D. (Petitioner).

Chris Leong, Deputy Attorney General, appeared pursuant to the provisions of Government Code section 11522.

Oral and documentary evidence having been received and the matter having been submitted, the Administrative Law Judge makes the following Proposed Decision.

FINDINGS OF FACT

1. The Medical Board of California (Board) issued Physician's and Surgeon's Certificate Number G 21095 to Petitioner on August 9, 1971. The certificate is renewed and current with an expiration date of May 31, 2017. Petitioner is a board certified psychiatrist.

2. By its Decision effective November 12, 2013, pursuant to a Stipulated Settlement reached by the parties on September 30, 2013 and adopted by the Board on October 24, 2013, the Board revoked Petitioner's certificate, stayed the revocation and placed Petitioner on probation for a period of five years on terms and conditions including, but not limited to, maintaining a record of controlled substances prescribed for others,

completing 40 hours per year of educational programs or courses, completing a prescribing practices course, completing a medical record keeping course, completing a professionalism program, completing a clinical training program, undergoing supervision by a practice monitor, and limiting his prescribing of Schedule II, III, and IV drugs to Adderall, Ritalin, Provigi, Klonopin, Xanax, and Ativan only.

3. The Board based its discipline on Petitioner's gross negligence, repeated negligent acts, incompetence, failure to maintain adequate and accurate records, and unprofessional conduct, all in connection with his care of three patients: Patients ER, KH, and RS.[1]

*Patient ER*

4. On September 15, 2006, Patient ER, who was a 39-year-old female, began receiving psychiatric treatment from Petitioner to address her depression, obsessional worries, and marital discord. Patient ER saw Petitioner for one-hour sessions about 36 times until she died on January 8, 2009. During the time she underwent treatment with Petitioner, Patient ER suffered at least one transient ischemic attack (TIA) or stroke-like symptoms, and underwent the repair of an atrial septal defect (i.e., a hole in the wall of the heart's upper chambers). Additionally, she suffered from a congenital abnormality of the lumbosacral region known as Bertolotti's Syndrome resulting in L5 nerve root pain. Although Patient ER suffered chronic pain problems, an atrial septal repair, a TIA resulting in transient monocular blindness, and multiple epidurals, Petitioner failed to indicate in Patient ER's medical records whether he consulted or conferred with any of the multiple physicians treating Patient ER at that time.

5. Petitioner initially treated Patient ER for Bipolar II disorder with 200 milligrams (mg.) of lamotrigine, twice daily, an anti-convulsant, with little notation in Patient ER's medical records of its efficacy. Petitioner labeled Patient ER as a "rapid metabolizer" (i.e., the propensity to process medication so fast, the drug has no chance to reach optimal blood levels, leading to limited amounts of drug that can act on the patient's system) without checking her blood plasma levels for the medications he prescribed against the doses she took. Petitioner also diagnosed Patient ER with obsessive compulsive disorder, although his notes indicated the patient's concerns were ruminations, rather than obsessions or compulsions.

6. Petitioner had no background, training, knowledge, or expertise in the field of pain management or addiction. With no indication, explanation, or documentation in the medical records, Petitioner changed his treatment of Patient ER from psychiatric to virtually pure pain management to address Patient ER's chronic back pain; however, Petitioner did not perform a medical examination of Patient ER. Petitioner did not develop a treatment plan,

[1] Patients are identified by their initials to protect their privacy.

obtain informed consent from Patient ER regarding the dangers of using controlled substances, and did not document periodic chart reviews.

7. Petitioner's notes were a narrative of his thoughts and feelings about his sessions with Patient ER, as well as his thoughts about orthopedic and pain management procedures, without any clear foundation. Petitioner's notes did not provide an objective measurement of Patient ER's mental state, and did not describe plans of current treatment, the efficacy of the treatments, or consideration of alternative treatments.

8. In 2008, Petitioner began prescribing Norco to Patient ER, even though Patient ER was bipolar and had a family history of alcohol abuse. Norco is contraindicated in those circumstances. Petitioner failed to recognize Patient ER's propensity to abuse controlled substances. Initially, in February 2008, Petitioner prescribed Norco 10 mg. #360 per month, but determined it was not strong enough to control Patient ER's pain level. Consequently, in May 2008, Petitioner changed her prescription to OxyContin 10 mg. #360 per month, while simultaneously prescribing Xanax 1.0 mg. #120 per month, and adding the muscle relaxant Soma 350 mg., which she was instructed to take approximately three times per day. When Patient ER complained of feeling over-sedated, Petitioner prescribed 90 mg. per day of Adderall XR (an amphetamine). Petitioner's notes indicated that the addition of Adderall would enhance the analgesic effect of OxyContin.

9. Patient ER repeatedly ran out of her medications early, thereby resulting in frequent requests that Petitioner refill her prescriptions early. There were additional indications that Patient ER was abusing her medications, but Petitioner did not consider these factors to be a problem, and continued to prescribe high doses of narcotics, muscle relaxants, and anxiolytics. Petitioner created a severe opiate dependency in Patient ER, and increased her narcotics and muscle relaxants based on her subjective reports of her status rather than on objective findings. Petitioner did not consult with a pain management specialist and did not coordinate her treatment with her other physicians. Additionally, Petitioner did not check the Controlled Substance Utilization Review and Evaluation System (CURES) or obtain any history to determine whether Patient ER was seeking medications from other physicians. The combination of drugs Petitioner prescribed created the potential for a dangerous drug overdose.

*Patient KH*

10. In July 1986, Patient KH, who was a 35-year-old female, began receiving psychiatric treatment from Petitioner to address her depression, panic disorder with agoraphobia, obsessive compulsive disorder, social phobia, and bulimia. Petitioner provided very little documentation in the records to support these diagnoses. In addition, Petitioner diagnosed Patient KH with intermittent prescription drug abuse of benzodiazepines, abuse of hydrocodone and Seroquel, and histrionic, dependent, and avoidant personality disorders. There was very little documentation in the records to support these additional diagnoses. Petitioner did not perform a medical examination of Patient KH. Petitioner did not develop a

treatment plan or obtain informed consent from Patient KH regarding the dangers of using controlled substances, and did not document periodic chart reviews.

11. In 1986, Petitioner initially treated Patient KH with 1.0 mg. of Xanax, which he increased to 4 mg. per day. Petitioner continued to prescribe Xanax to her at that dosage for 10 years until 1996. Petitioner attempted to try alternative medications to Xanax, but Patient KH claimed that those medications were intolerable and/or ineffective. By December 1993, Patient KH had become dependent on Xanax, and was taking 6 mg. per day. By February 1996, Patient KH developed back pain, and Petitioner prescribed 10/325 Vicodin. In 1997, Petitioner changed Patient KH's prescription to14 mg. per day of Klonopin (a benzodiazepine used to treat anxiety). In June 1997, when Patient KH complained of migraines, Petitioner prescribed #30 Viocodin, with no neurological work-up. In 1998, Patient KH began obtaining prescriptions for narcotics from other physicians. Her family placed her in a substance abuse/detox program. In 1999, Petitioner became aware that Patient KH had been abusing Klonipin (up to 20 mg. per day). As a result, Petitioner attempted to reduce Patient KH's dose. However, Petitioner still continued prescribing large amounts of Klonopin #240 2 mg. In November 2000, Petitioner prescribed 16 mg. of Klonopin, and added 200 mg. of Seroquel (an antipsychotic medication), and 60 mg. of Remeron (an antidepressant).

12. In September 2009, Petitioner enlisted the help of Patient KH's husband to monitor and dispense Patient KH's medications. This plan failed. Patient KH overused Klonopin and Seroquel. In 2010, Petitioner attempted to switch Patient KH's medication to Abilify (an antipsychotic), which she rejected. Patient KH remained on Seroquel, and Petitioner prescribed Klonopin with six refills. Patient KH, who had a high body weight, took 1000 mg. of Seroquel per day, and subsequently developed a true metabolic syndrome as a function of the Seroquel. Petitioner identified Patient KH as a rapid metabolizer. Petitioner was unable to differentiate between a patient who had developed progressive tachyphylaxis (decreased response after repetitive administration of a substance) and a patient who was a true rapid metabolizer.

13. On February 27, 2011, Patient KH died in her sleep. The cause of death was hypertensive heart disease.

14. A March 31, 2011 toxicology report stemming from a February 28, 2011 autopsy showed positive findings from matrix source blood, including a result of 8.4 ng/mL of Clonazepam and 150 ng/mL of Amino Clonazepam.

*Patient RS*

15. On January 15, 2007, Petitioner met with 50 year old male Patient RS for an initial visit. Previously, Patient RS had been diagnosed with hypogonadism (low testosterone level) and received maintenance injections of testosterone cyprionate for 10 years. Petitioner did not perform a medical examination of Patient RS. Instead, Petitioner took at face value Patient RS's history and his representations that without hormone

replacement, he would become irritable, socially withdrawn and demanding. Petitioner did not confer with any of Patient RS's physicians to confirm the history of hypogonadism. Without providing any indication in the record, Petitioner began prescribing testosterone cyprionate 200 mg. Q7 days by injection. Petitioner did not include documentation in the record that he ever checked Patient RS's prostate-specific antigen, performed a prostate examination, or asked Patient RS whether he was using high levels of testosterone to improve his bicycling performance. Petitioner did not develop a treatment plan, obtain informed consent from Patient RS regarding the dangers of using controlled substances, document periodic chart reviews, or confer with Patient RS's other physicians. Petitioner engaged in the practice of endocrinology without the medical knowledge, training or skill to support this practice. Petitioner's use of testosterone cyprionate exceeded the usual and customary dose for this agent. Petitioner did not consider the possibility of testicular atrophy, prostatic enlargement, the risk of prostate cancer, or other problems related to the use of androgenic steroids.

16. Shortly into his treatment, when Patient RS complained of depression, Petitioner prescribed Sertraline 50 mg. (an antidepressant). In 2008, Petitioner treated Patient RS's depression with Effexor XR 150 mg. and Abilify 5 mg. He also prescribed Trazadone for sleep.

17. In 2010, when Patient RS had dental surgery, Petitioner prescribed Norco 10/325 for pain, although Patient RS's dentist advised him to take Advil. On August 16, 2010, Patient RS contacted Petitioner and said he had acute back strain. Petitioner again prescribed Norco 10/325. On August 30, 2010, Petitioner indicated in his progress notes that he discussed with Patient RS the success rate of back surgery.

18. On December 28, 2010, Patient RS underwent lumbar spine surgery at Kaiser. The Kaiser physicians prescribed methylprednisolone (a corticosteroid) and hydrocodone (an opiate) 10/325 #100 to be used every four hours as needed for pain. In January 2011, Patient RS requested that Petitioner provide post-surgical pain management. Petitioner became involved in an ongoing process of evaluating Patient RS based on his reported pain level with and without medication, self-reports of functional impairment, self-reports of lifting and standing capacity and duration of walking. Although the Kaiser physicians had prescribed hydrocodone to Patient RS, Petitioner prescribed OxyContin 40 mg. twice a day. Petitioner did not have the requisite knowledge, skill or training in pain management. Seven weeks post-surgery, when Patient RS complained of intolerable pain, Petitioner maintained Patient RS on OxyContin 20 mg. twice a day, and also advised him as to his surgical prognosis. Five months post-surgery, Petitioner prescribed 10 mg. Oxycodone six per day, to which he added carisprodol (Soma) 350 mg. twice a day, as well as Cymbalta as an analgesic. Six months post-surgery, Petitioner continued to treat Patient RS with his pain medicine regimen without performing a physical examination, seeking a consultation, or verifying disability other than through Patient RS's self-reports. Petitioner then increased Patient RS's oxycodone, and prescribed eight per day. Petitioner deviated from his treatment plan only when Patient RS informed him that Petitioner was the subject of a Medical Board investigation.

*Probation Compliance*

19. For nearly three-and-one-half years, Petitioner has scrupulously complied with all probationary terms imposed by the Board. Specifically, he has maintained a record of all controlled substances he has prescribed; successfully completed 40 hours of approved educational programs or courses for each year of probation, in addition to Continuing Medical Education requirements for renewal of licensure; successfully completed the Physician Assessment and Clinical Education Program (PACE); successfully completed the Medical Record Keeping Course offered by PACE; completed the Prescribing Practices Course offered by PACE; successfully completed an ethics course; has worked closely with his practice monitor, Dr. Kristy Lamb, who was a member of the PACE program; refrained from prescribing Schedule II, III, and IV drugs, except for the six permitted by the Board: Adderall, Ritalin, Provigi, Klonopin, Xanax, and Ativan; and submitted timely quarterly declarations stating that he has been in compliance with all conditions of probation.

*Petitioner's Petition and Testimony*

20. Petitioner has an out-patient psychiatry practice in which he performs psychotherapy and manages the medication of his patients. Petitioner currently has 40 patients and sees approximately 10 patients per week.

21. The Board's probation has served Petitioner well. The entire experience forced Petitioner to learn a great deal about the practice of pain management, how it has evolved over the years, its high degree of sophistication, and how antithetical it is to the practice of psychiatry. This is because California's standards now require pain management patients to submit to drug monitoring and urine analysis, which could conflict with the demonstration of trust psychiatrists must convey to their patients. For this reason, Petitioner has committed to not practicing pain management even after the termination of his probation. Instead, Petitioner now refers, and will continue to refer, such patients to pain specialists, because pain specialists have the expertise and resources to treat such patients properly and appropriately.

22. Dr. Lamb has provided Petitioner with consistent feedback concerning his medical practice from 2014 to the present, which has resulted in Petitioner learning to prepare consistently superior, organized, and comprehensive notes in his patients' medical records.

23. Petitioner has incurred extensive financial costs complying with the terms of his probation. Specifically, Petitioner pays PACE $12,500 per year for practice monitoring services. Additionally, Petitioner pays $4,080 per year for probation inspectors. Petitioner also pays approximately $10,000 per year to fulfill the required 40 hours of approved educational programs or courses, specifically for airfare, lodging, and other travel expenses to attend the classes, as he is prohibited from taking such classes online. Finally, Petitioner's malpractice insurance premiums have doubled from $5,000 to $10,000 per year as a result of his probationary status.

24. Before his probation, Petitioner worked for a non-profit organization that provided medical services for underserved communities. Since he has been on probation, he has not been permitted to perform services for the non-profit organization, because it would require the organization to pay significantly more for malpractice insurance to have Petitioner perform medical services on the organization's behalf.

25. Because Petitioner must refrain from prescribing Schedule II, III, and IV drugs, except for the six permitted by the Board, he is precluded from prescribing newer, gentler, more effective Schedule II, III, and IV medications designed to do the same thing.

26. Petitioner is 73 years old and would like to practice with no restrictions, as well as return to providing medical services to underserved communities, which is why he has not only complied with probation, but has done so in a stellar fashion. However, complying with the terms of his probation has proven to be very expensive, requiring him to pay thousands of dollars for practice monitoring, probation inspection, medical educational courses and programs, and malpractice insurance fees. Additionally, Petitioner is precluded from using newer drugs that can help his patients in a more effective manner, as probation has limited the medications he can prescribe. For these reasons, probation has become unduly burdensome. However, because probation has resulted in him making positive and permanent changes to his practice, Petitioner contends the public is fully protected, rendering unnecessary the continuation of probation.

27. In support of the Petition, Petitioner submitted a letter from Lewis Engel, M.D. Dr. Engel, who shares office space with Petitioner, declared under penalty of perjury, in part:

> I know [Petitioner] to be an outstanding clinician who is dedicated to his patients. [. . .] His practice is limited exclusively to psychiatry. He refers any and all medical problems to outside specialists. His medical charting is exemplary, detailed and thorough. [. . .] My trust and confidence is reflected by the fact that I regularly refer patients to [Petitioner] and the feedback is consistently positive.

28. Petitioner also submitted a letter from Gary Wm. Grubb, M.D., who wrote, under penalty of perjury, the following:

> In my professional association over the course of many years, I have referred patients to [Petitioner] for various psychiatric conditions. He has proven himself to be an outstanding physician with accuracy in his diagnostic and treatment work and persistent in his follow-up care which resulted in excellent patient outcomes of recovery from or amelioration of their psychiatric problems. I have no reservation about recommending [Petitioner] again to a patient or friend with psychiatric problems. He limits his practice strictly to Psychiatry.

29. Based on all of the evidence adduced at the hearing, it is found that the chance of any "recidivism" by Petitioner is very low. The public interest would not be put at risk by terminating his probation one and one-half years before it is due to expire by its own terms.

## CONCLUSIONS OF LAW

*Statutory Authority*

1. Business and Professions Code section 2307 provides, in part:

(a) A person whose certificate has been surrendered while under investigation or while charges are pending or whose certificate has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the certificate or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from physicians and surgeons licensed in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed

decision to the board or the California Board of Podiatric Medicine, as applicable, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the certificate was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a certificate or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

*Regulatory Authority*

2. California Code of Regulations, title 16, section 1360.2 provides in part:

When considering a petition for reinstatement of a license, certificate or permit holder pursuant to the provisions of Section 11522 of the Government Code, the division or panel shall evaluate evidence of rehabilitation submitted by the petitioner considering the following criteria:

(a) The nature and severity of the act(s) or crime(s) under consideration as grounds for denial.

(b) Evidence of any act(s) or crime(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial which also could be considered as grounds for denial under Section 480.

(c) The time that has elapsed since commission of the act(s) or crime(s) referred to in subsections (a) or (b).

(d) In the case of a suspension or revocation based upon the conviction of a crime, the criteria set forth in Section 1360.1, subsections (b), (d) and (e).

(e) Evidence, if any, of rehabilitation submitted by the applicant.

*The Burden and Standard of Proof*

3. In a proceeding to restore a disciplined professional license or a petition for penalty relief, the burden rests on the petitioner to prove that he has rehabilitated himself and that he is entitled to have his license restored or be relieved from further requirements of probation. (*Flanzer v. Board of Dental Examiners* (1990) 220 Cal.App.3d 1392, 1398.)

4. A person seeking reinstatement or penalty relief must present strong proof of rehabilitation and a sufficient showing of rehabilitation to overcome the Board's former adverse determination. (*Hippard v. State Bar of California* (1989) 49 Cal.3d 1084, 1092-1093.)

5. The standard of proof is clear and convincing evidence. (*Hippard v. State Bar of California, supra*, 49 Cal.3d at p. 1092.)

*Relevant Factors in Determining Rehabilitation*

6. Petitioner has no other disciplinary record, which is a mitigating factor. (*Segretti v. State Bar of California* (1976) 15 Cal.3d 878, 888.)

7. Rehabilitation is a "state of mind" and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) Petitioner has complied with all terms of his probation.

*Cause Exists to Grant the Petition and Terminate Probation*

8. Petitioner's medical competence over the past three-and-one-half years has not been questioned and he has demonstrated himself to be a competent, well-liked physician. Respect within the medical community evidences that he is well along in the process of rehabilitation. (See *In re Dedman* (1976) 17 Cal.3d 229, 234.) Additionally, the evidence shows that Petitioner has been a model probationer, given his timely completion of his probation conditions. He has successfully completed PACE, the Medical Record Keeping Course offered by PACE, and Continuing Medical Education requirements, learning and appreciating the evolution of pain management and concluding it should have no role in his psychiatry practice. The Board allowed Petitioner to continue practicing psychiatry and prescribing medication during his probation, and Petitioner credibly testified he does so within the limitations set by the Board. While Petitioner has suffered financially in order to comply with his probation conditions, it is important to note that that factor has limited application in determining whether Petitioner's probation should be terminated. Rather, Petitioner's impact on the public, and whether he poses a danger to it, is given maximum consideration. In that regard, Petitioner has demonstrated clearly and convincingly that the public would be in no danger if his probation is terminated, particularly given his commitment to refrain from engaging in the practice of pain management, coupled with his

completion of comprehensive courses and programs, such as PACE and a Medical Record Keeping Course, and the superior manner in which he now maintains his medical records as addressed by the practice monitor.

9. Given the above, cause exists under Business and Professions Code section 2307 and California Code of Regulations, title 16, section 1360.2, to grant the petition and terminate the Board's probation .

## ORDER

The petition of Joseph Ralph Sicignano, M.D. for termination of probation is granted. Physician's and Surgeon's Certificate Number G 21095 is fully restored.

Date: April 28, 2017

DocuSigned by:
Carla L. Garrett
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CARLA L. GARRETT
Administrative Law Judge
Office of Administrative Hearings